ARIZONA STATE VETERINARY MEDICAL EXAMINING BOARD
1740 W. ADAMS ST., SUITE 4600, PHOENIX, ARIZONA 85007
PHONE (602) 364-1 PET (1738) FAX (602) 364-1039
VETBOARD.AZ.GOV

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COMPLAINT INVESTIGATION FORM

If there is an issue with more than one veterinarian please file a separate Complaint Investigation Form for each veterinarian

PLEASE PRINT OR TYPE

FOR OFFICE USE ONLY

Date Received: Nov. 1, 2021 Case Number: 22-46

A. THIS COMPLAINT IS FILED AGAINST THE FOLLOWING:

Name of Veterinarian/CVT: Carie Bikson

Premise Name: Banfield

Premise Address: 10825 N. Tatum Blvd.

City: Phoenix State: AZ Zip Code: 85028

Telephone: (480) 609-9695

B. INFORMATION REGARDING THE INDIVIDUAL FILING COMPLAINT*:

Name: Pat A. Johnson

Addre[redacted]

City[redacted] State: [redacted] Zip Cod[redacted]

Home Telepho[redacted] Cell Telephone:

**STATE LAW REQUIRES WE HAVE TO DISCLOSE YOUR NAME UNLESS WE CAN SHOW THAT DISCLOSURE WILL RESULT IN SUBSTANTIAL HARM TO YOU, SOMEONE ELSE OR THE PUBLIC PER A.R.S. § 41-1010. IF YOU HAVE REASON TO BELIEVE THAT SUBSTANTIAL HARM WILL RESULT IN DISCLOSURE OF YOUR NAME PLEASE PROVIDE COPIES OF RESTRAINING ORDERS OR OTHER DOCUMENTATION.*

C. **PATIENT INFORMATION (1):**

Name: Toby Johnson

Breed/Species: Canine Bichon Mix

Age: 8-10 years Sex: Male Color: White

PATIENT INFORMATION (2):

Name: _____

Breed/Species: _____

Age: _____ Sex: _____ Color: _____

D. **VETERINARIANS WHO HAVE PROVIDED CARE TO THIS PET FOR THIS ISSUE:**

Please provide the name, address and phone number for each veterinarian.

Carie Bikson: Banfield (provided above)

Rebecca Rittenberg, DVM, Internal Medicine, Phoenix Veterinary Hospital, 4015 E. Cactus Rd., Phoenix, AZ 85032

Dr. Aubrey Pruitt, Four Peaks Animal Clinic, 10818 N. Scottsdale Rd., 480-778-1770

E. **WITNESS INFORMATION:**

Please provide the name, address and phone number of each witness that has direct knowledge regarding this case.

Kimberly Christense[redacted]

Attestation of Person Requesting Investigation

By signing this form, I declare that the information contained herein is true and accurate to the best of my knowledge. Further, I authorize the release of any and all medical records or information necessary to complete the investigation of this case.

Signature: Pat A. Johnson

Date: 10/31/2021

F. ALLEGATIONS and/or CONCERNS:

Please provide all information that you feel is relevant to the complaint. This portion must be either typewritten or clearly printed in ink.

12-23-2020 We took Toby in to seek treatment for an ongoing ear infection. We asked for the 'one and done' treatment whereby they inject medicine into his ear.
12-25-2020 Toby was very ill. Disoriented, unable to eat, did not seem to know what was happening around him. 12-26-2020 We took Toby in and Dr. Carie Bickson came out and explained that Toby had a busted eardrum. We wondered if the injectable medication could have had anything to do with this.
8-14-2021 We took Toby in for his comprehensive exam and teeth cleaning. Bloodwork was done prior to the teeth cleaning which showed that Toby seemed to have no health issues at the time. The teeth cleaning was performed by Dr. Carie Bickson. When we picked up Toby, we were advised that Toby would be a little groggy and maybe a little nauseous, but that he should be back to normal within about 36 hours.
8-15 through 8-17 Toby was lethargic, looked ill and was unwilling to eat. There was a lot of vomiting. We decided to take him back to Banfield for an assessment.
8-17-2021 Pat Johnson took Toby in for an assessment. They sent her home with a nausea pill. No attempt was made to evaluate why our dog was so sick. The dog was unable to keep food down, so he was certainly unable to stomach a nausea pill. I told Pat to take him back to Banfield.8-18-2021 The vet on staff that day gave Toby subcutaneous fluids and an injection for nausea, but no attempt was made to determine the cause of the nausea. 8-19-21 Our dog was still unwilling to eat anything and looked terrible. I wrote a letter to Banfield, requesting that they do an evaluation on Toby instead of just treating the symptoms. I sent the letter with Pat.
8-20-2021 Toby was dropped off at Banfield. The tech said they could tell from his color that he had jaundice. They verified acute liver trauma through a blood test. No attempt was made, however, to treat the condition even though the dog was there all day. They did not give him an IV, an antibiotic, denamarin or any treatment whatsoever. When we came to pick him up in the evening, we told the tech Heather Schroeder that we were extremely unhappy with the quality of care that our dog was getting, and we demanded a record of all the medications that had been given to our dog the day of the teeth cleaning. Not only did they not attempt any form of treatment that day, but they did not suggest that we take him to an emergency hospital, as we ended up doing the next day. 8-21-2021 We took Toby to Phoenix Veterinary Hospital Toby's condition was evaluated as serious, and he was admitted to the ICU for two nights. There he received IV fluids, antibiotics, and other drugs to treat his liver, as well as an ultrasound of his abdominal cavity. Toby's liver improved slightly over the two days, which led the doctor to determine that the hepatitis was acute and not chronic. We scheduled follow up appointments for Toby with the internal medicine doctor on site.
Reviewing the above narrative, the following observations emerge:
1. Two negative health events happened to Toby while under Banfield' s care which may have been caused by the vets/techs but we have no substantial proof.
2. There is definite neglect in providing prompt and appropriate care for an ailing dog. This neglect could have resulted in the death of our dog.
3. The facility is overbooked with vaccination and teeth cleaning appointments, and they do not leave time slots available for sick pets.
Based on these observations, we will be submitting a formal complaint to the Arizona State Veterinary Examining Board.

December 9, 2021

Tracy Riendeau, CVT
Investigator
Arizona State Veterinary Medical Examining Board
1740 W Adams St, Ste 4600
Phoenix, AZ 85007
[redacted]

Re: *Carie Bikson, DVM #22-46*

Dear Ms. Riendeau:

Thank you for the opportunity to respond to PJ's Board complaint. On August 14, 2021, I conducted a comprehensive examination with dental cleaning on Toby, a Maltese male, date of birth July 12, 2013. On August 14, 2021, I performed Toby's dental cleaning under anesthesia monitoring his vital signs during the procedure. As documented in the medical record, Toby's vital signs remained normal while under sedation and postoperatively.

On July 15, 2019 and July 16, 2020, I performed Toby's dental cleanings under general anesthesia, and he tolerated the procedures well and had no complications postoperatively. On August 14, 2021; July 15, 2019; and July 16, 2020; I used the ***same medication (Propofol, Midazolam, and Butorphanol) at approximately identical dosages*** to sedate Toby.

On July 15, 2019, Toby received 0.2 mLs IV of Butorphanol, 0.2 mLs IV of Midazolam, and 2.5 mLs IV of Propofol. On July 16, 2020, Toby received 0.21 mLs IV of Butorphanol, 0.21 mLs IV of Midazolam, and 3.0 mLs IV of Propofol. On August 14, 2021, Toby received 0.21 mLs IV of Butorphanol, 0.21 mLs IV of Midazolam, and 3.0 mLs IV of Propofol.

Toby did not experience an adverse reaction to the sedation medication on July 15, 2019 or on July 16, 2020. On August 14, 2021, there was no indication that Toby had experienced an adverse reaction during the procedure or before his discharge postoperatively. Again, on August 14, 2021, Toby received the same sedation medication at approximately identical dosages that he had received in 2019 and 2020. On August 14, 2021, Toby had normal vital signs before, during, and after the procedure. Also, there was nothing about his post-sedation presentation on August 14, 2021 to indicate an adverse reaction to the sedation medication. Consequently, I had no reason to believe the sedation medication had negatively affected Toby in some way on August 14, 2021.

In response to JP's Board complaint, I submit the following:

- I did ***not*** see or treat Toby's ear infection on December 23, 2020.
- On December 26, 2020, I evaluated Toby and diagnosed his ruptured ear drum AS, otitis externa (medical) of both ears. On that date, my physical examination of Toby revealed inflammation of his right and left pinna, yellowish/green exudate from his right ear, and

brown exudate from his left ear. I administered 0.65 mLs SQ of Covenia (8 mg/mL) to Toby in hospital and prescribed gabapentin 100 mg, 1 capsule BID x 7 days. I documented that I discussed my ear findings, including the ruptured ear drum and treatment, in depth with PJ. I recommended no bathing of Toby's head until got all clear from the vet, and asked JP to bring Toby back for a recheck in 2 weeks.

- I did ***not*** treat Toby after August 14, 2021. Instead, other doctors at Banfield Pet Hospital cared for Toby on August 15, 2021; August 17, 2021; August 18, 2021; August 20, 2021; and August 14, 2021..

I respectfully submit that my treatment of Toby met the standard of care and ask the Board to dismiss this case. I have attached Toby's Banfield Pet Hospital chart as Exhibit 1.

I. <u>My Care and Treatment of Toby on August 14, 2021</u>

On August 14, 2021, Toby's preoperative physical examination and his vital signs were within normal limits. On that date, I documented the following regarding my physical examination of Toby:

Vitals Observations: T: 100.1, P: 130, R: 30, BAR CRT <2 seconds / / MM: pink, moist.
Nutritional Observations: BCS: 5/9, WT: 6.99 kg.
Coat & Skin: Clean, full haircoat with no evidence of ectoparasites, no lesions or masses observed, normal nails.
Ocular Observations: Clear cornea OU, no discharge OU, no conjunctival hyperemia or episcleral injection OU, NS OU, iris atrophy OU.
Otic Observations: Clean and clear AU, no erythema observed AU.
Oral and Nasal Observations: Calculus: 3/4, Gingivitis: 2/4, no nasal discharge observed.
Respiratory Observations: Normal bronchovesicular sounds in all fields, no crackles or wheezes observed, no inducible cough upon tracheal palpation.
Cardiovascular Observations: Normal rate and rhythm, no murmur, no arrhythmias observed, strong and synchronous femoral pulses.
Lymph: Small, soft symmetrical peripheral lymph nodes.
Abdominal Observations: Soft, non-painful abdomen, no palpable masses or organomegaly observed.
Urogenital Observations: Normal external anatomy, pink and moist mucous membranes.
Neurological Observations: Appropriate mentation, normal proprioceptive positioning, no ataxia observed in all 4 limbs, cranial nerves intact.
Toby has:
Generalized <moderate> plaque.
Generalized <moderate> calculus.
Generalized <moderate> gingivitis.

Preinduction Evaluation:
Time: 09:28.
Temp: 100.5, HR: 90, RR: 20, Pulse Quality: str, Other physical examination changes: None.

Sedation level: Adequate.

On August 14, 2021, I stated the following under **Plan** in pertinent part:

IV Catheter:
Size (gauge): 20
Right cephalic.

Equipment:
Anesthesia Machine Checklist completed: Yes.
Breathing Circuit:
Non-rebreathing: (<7kg)
Bag Size (L): 1.

Induction and Intubation Phase:
Preoxygenation administered: No.
Endotracheal tube size: 6 mm.
Cuff inflated for leak test: Yes.

IV induction agent and concentration: Propofol 10mg/ml
Quantity: 3ml, Time: 09:30, Administered by: AC.

Comprehensive Physical Examination/Dental prophy:
CBC/IOF/Electrolytes: nsf
Fecal: nsf
Urinalysis: USG 01.040; inactive sediment
Bladder Scan performed
Distention: No
Cystocentesis: Yes
Uroliths: No
Particulate Matter: No
Mass Effect; Or Other Abnormality: No
4DX: and
Express Anal Glands
ECG: nsr
Recommended Flea Control: First Shield Trio, Simparcia
Recommended Home Dental Care: Brushing with an enzymatic toothpaste, water additive, greenie dental chews.

1. Prognosis: Good
2. Client Education: PE results, test results, vaccine reactions, ***standard post-anesthesia discharge instructions***, dental discharge handout-tgh
3. Recheck: 6 months
4. Follow-Up Therapy: CPE

Oral Health: Discussed that pet has a moderate amount of dental calculus/plaque accumulating on the teeth. A dental cleaning is recommended in the next 4-5 months to remove the dental calculus. After the dental calculus is removed, daily teeth brushing, a dental diet or dental chews are recommended to reduce the accumulation of the dental calculus.

Joint Supplementation: In order to help reduce the risk of osteoarthritis and support the joints, lifelong supplementation with PhyCox or Cosequin is recommended. Maintaining a healthy weight is also very important for supporting joint health.

Recommendations:
Home dental care: Yes
Routine Dental Prophylaxis: All teeth scaled with an ultrasound scaler, all teeth polished with prophy paste. Examination of the oral cavity completed by the veterinarian including assessment of all teeth with dental probe.

Dental Chart:
Calculus (0-4): 2
Gingivitis (0-4): 2
Periodontal Disease (0-4): 0
Bite: Level
Oral Cavity: None
Missing: 110, 109, 106, 105, 103, 102, 101, 201, 202, 203, 205, 206, 207, 208, 210, 411, 410, 405, 403, 402, 40, 301, 302, 303, 205, 308, 311.
Retained: None
Pathology: PF RE 108, PF RE 209, ED 409, ED 404, RE 304, ED PF 306, ED 307. ED 309.
[Fractured Closed/Open (FC/FO), Worn (W), Pockets (PK mm), Caries (C), Mobility (M 1-3), Neck Lesion (NL), Root Exposure (RE)].

Patient ASA Status (I-IV):1
Preoperative Pain Assessment (0-4): 0
Anesthesia Protocol Utilized: Geriatric

Premedications Administered:

1. Medication: Butorphanol Concentration (mg/ml): 10
   Quantity (mL): 0.21, Route: IV
   Time Administered: 08:31, Administered by: CB
2. Medication: Midazolam Concentration (mg/ml): 5
   Quantity (mL): 0.21, Route: IV
   Time Administered: 08:31, Administered by: CB
3. Rx: Fluid Administration-Lactated Ringers Solution
   Instructions: Administer 9.4 mls one time

Patient presents for dnt. Owner reports doing well at home.
e/d/u/d: Normal
c/s/v/d: None

Meds: None
Diet: Healthy balance 1 cup a day and little bit of chicken
HWP, flea/tick prevention
Phone # to call (if d/o):
Checked in by: AC.

(Emphasis added in bold and italics).

On August 14, 2021, I ordered a CBC, CMP, fecal tests, and a urinalysis on Toby. On that date, Toby's CMP revealed the following in pertinent part:

Albumin: 3.3 g/dL (2.200-3.900)
Alkaline Phosphatase: 27.0 U/L (23.000-212.000)
ALT/SGPT: 37.0 U/L (10.000-125.000)
BUN: 13.0 mg/dL (7.000-27.000)
Creatinine: 0.7 mg/dL (0.5.00-1.800)
GGT: 0.0 U/L (0.000-11.000)
Bilirubin: 0.2 mg/dL (0.000-0.900)
Protein, Total: 7.4 g/dL (5.200-8.200)
ALB/Glob: 0.8
BUN/Creatinine: 17.0

On August 14, 2021, Toby's CBC revealed the following in pertinent part:

WBC: 12.11 10^9/l (6.000-17.000)
Lymphocyte: 1.05 10^9/l (1.000-4.800)
Monocyte 0.84 10^9/l (0.200-1.500).
Neutrophil: 10.11 10^9/l (3.000-12.000)
Hemoglobin: 15.4 g/dl (12.000-18.000)
Hematocrit 49.75% (37.000-55.000)
Platelet Count: 252.0 10^9/l (165.000-500.000)

Toby's August 14, 2021 EKG showed a normal sinus rhythm.

On August 14, 2021, we sedated Toby with 0.21 mLs IV of Midazolam 5mg/mL; 0.21 mLs IV of Butorphanol 10mg/mL, and 3 mLs IV of Propofol.

On August 14, 2021, we documented the following while Toby was under sedation:

Time:	09:35	09:40	09:45	09:50
Sevo%	2.5	2.5	2	2
O2 Flow	3	2	2	2
Fluids (ml/hr)	35	35	35	35
HR	87	114	129	143
RR	12	28	34	54
Pulse quality	str	str	str	str

CRT/MM	<2/pk	<2/pk	<2/pk	<2/pk
Temperature	97.8	98.4	99.6	99.6
SpO2	97	95	94	94
ECG rhythm	nsr	nsr	nsr	nsr
EtCO2	37	39	37	31
SAP	130	130	133	124
DAP	87	92	95	88
MAP	101	105	108	100

Procedure/surgery start time: 09:35
Procedure end time: 09:52
Inhalant anesthesia end time: 09:52
100% O2 end time: 09:57
Total fluids administered during anesthesia: 9.4 ml LRS IV

Patient Parameters at Extubation:
Time Extubated: 09:58
Temperature: 99.6
HR: 143
RR: 31
Pulse Quality: Str
SpO2: 94%
SAP: 124
DAP: 88
MAP: 115

Postoperative Pain Assessment (0-4): 0
Recovery:
Final postanesthetic evaluation performed by: CB
Time: 15:00
Evaluation: Recovered

CONCLUSION

On July 15, 2019 and July 16, 2020, I performed Toby's dental cleanings under sedation, and he tolerated the procedures well and had no complications postoperatively. On August 14, 2021; July 15, 2019 and July 16, 2020, I used the ***same medication (Propofol, Midazolam, and Butorphanol) at approximately identical dosages*** to sedate Toby.

Toby did not experience an adverse reaction to the sedation medication on July 15, 2019 or July 16, 2020. On August 14, 2021, there was no indication that Toby had experienced an adverse reaction during the procedure or before his discharge postoperatively. Again, on August 14, 2021, Toby received the same sedation medication at approximately identical dosages that he had received in 2019 and 2020. On August 14, 2021, Toby had normal vital signs before, during, and after the procedure. Also, there was nothing about his post-sedation presentation on August 14, 2021 to indicate an adverse reaction to the sedation medication. Consequently, I had no

reason to believe the sedation medication had negatively affected Toby in some way on August 14, 2021.

I did ***not*** treat Toby after August 14, 2021. Instead, other doctors at Banfield Pet Hospital cared for Toby on August 15, 2021; August 17, 2021; August 18, 2021; August 20, 2021; and August 14, 2021.

I did ***not*** see or treat Toby's ear infection on December 23, 2020.

I respectfully submit that my treatment of Toby met the standard of care and ask the Board to dismiss this case.

Sincerely,

Carie Bikson, DVM

Douglas A. Ducey
- Governor -

Victoria Whitmore
- Executive Director -

ARIZONA STATE VETERINARY MEDICAL EXAMINING BOARD
1740 W. Adams Street, Ste. 4600, Phoenix, Arizona 85007
Phone (602) 364-1-PET (1738) * FAX (602) 364-1039
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INVESTIGATIVE COMMITTEE REPORT

TO: Arizona State Veterinary Medical Examining Board

FROM: PM Investigative Committee: Adam Almaraz - Chair
Amrit Rai, DVM
Steven Dow, DVM
Gregg Maura
Justin McCormick, DVM

STAFF PRESENT: Tracy A. Riendeau, CVT – Investigations
Elizabeth Campbell, Assistant Attorney General

RE: Case: 22-46
Complainant(s): Pat A. Johnson
Respondent(s): Carie Bikson, DVM (License: 6931)

SUMMARY:
Complaint Received at Board Office: 11/1/21
Committee Discussion: 4/5/22
Board IIR: 5/18/22

APPLICABLE STATUTES AND RULES:
Laws as Amended August 2018 (Lime Green); Rules as Revised September 2013 (Yellow)

On August 14, 2021, "Toby," an approximately 8-year-old male Bichon/Maltese mix was presented to Respondent for a dental cleaning. Blood and urine was collected for testing and revealed the dog was a surgical candidate. The procedure was performed and the dog was discharged later that day.

August 17th through August 20, 2021, the dog was presented to Respondent's premises due to vomiting and not eating. The dog did not improve and blood work revealed elevated liver enzymes.

On August 21, 2021, the dog was presented to a specialist for advanced diagnostics and treatment. After evaluation and an abdominal ultrasound, acute hepatitis was suspected.

Complainant was noticed and appeared. Complainant's daughter, Ms. Christiansen, appeared. Respondent was noticed and appeared with counsel, T. Scott King.

The Committee reviewed medical records, testimony, and other documentation as described below:

- Complainant(s) narrative: *Pat A. Johnson*
- Respondent(s) narrative/medical record: *Carie Bikson, DVM*
- Consulting Veterinarian(s) narrative/medical records: *PVREC*

PROPOSED 'FINDINGS of FACT':

1. On December 23, 2020, the dog was presented to Respondent's associate to check the dog's ears. There was debris in both ears and the ears were treated with Osurnia.

2. On December 26, 2020, the dog was presented to Respondent for a recheck of the ears. Upon evaluation, she noted the left ear drum was ruptured and both ears had exudate. Respondent administered the dog Convenia and discharged the dog with gabapentin.

3. Complainant expressed concern that the ear medication caused the left ear drum to rupture. Respondent was not the veterinarian that treated the dog's ears on December 23, 2020.

4. On August 14, 2021, the dog was presented to Respondent for a dental cleaning. Upon exam, the dog had a weight = 15.4 pounds, a temperature =100.1 degrees, a heart rate = 130bpm and a respiration rate = 30rpm – all systems were normal except for moderate calculus, plaque and gingivitis. Blood and urine were collected for testing and nothing significant was found – the dog was a surgical candidate. An IV catheter was placed; the dog was pre-medicated with:

a. Butorphanol 10mg/mL, 0.21mLs IV; and
b. Midazolam 5mg/mL, 0.21mLs IV.

5. Prior to induction the dog's vitals were taken: T -100.5; HR – 90; and RR – 20. The dog was started on LRS fluids IV and induced with propofol 10mg/mL, 3mLs IV. The teeth were scaled, polished and assessed by Respondent with a probe. The dog was monitored while under anesthesia – total time approximately 15 minutes. The dog recovered uneventfully and was discharged later that day.

6. Respondent noted that she administered the same medication to the dog, at almost the exact same doses, as she did on the previous two dental procedures. Respondent did not see the dog again and was subsequently treated by her associates.

7. Complainant reported that at discharge she was advised the dog may be a little groggy and nauseous but should be back to normal within 36 hours. Over the next couple of days, the dog was lethargic, not eating and vomiting.

8. On August 17, 2021, the dog was presented to Respondent's associate for a recheck. The dog was evaluated and discharged with Cerenia.

9. On August 18, 2021, due to no improvement, the dog was seen by an associate of Respondent's. After the dog was evaluated, the dog was administered SQ fluids and an injection of Cerenia, and discharged with Fortiflora.

10. On August 20, 2021, the dog was again presented to an associate of Respondent's due to not improving. The dog was evaluated; blood work was performed and revealed increased liver enzymes. An AFAST was performed and revealed mild sludge in gall bladder and mild liver enlargement. Referral for abdominal ultrasound was recommended and the dog was discharged with Denamarin and sulcralfate. Complainant was able to secure an appointment at Phoenix Veterinary Referral & Emergency (PVRC) the following day.

11. On August 21, 2021, the dog was presented to PVRC for advanced diagnostics and evaluation. The dog was initially seen by Dr. Mital and then transferred to Dr. Rittenberg for an abdominal ultrasound. Dr. Rittenberg performed the ultrasound and based on those findings recommended radiographs. Based on the diagnostics, Dr. Rittenberg suspected acute hepatitis and supportive care was initiated.

12. The dog was hospitalized throughout the weekend on IV fluids, Denamarin, N-acetycysteine, and Cereina.

13. The following day the dog began to eat, was brighter on exam, and the liver enzymes began to improve. Dr. Rittenberg discussed with Complainant that this was potentially a reaction to the anesthesia from the dental procedure given the values were completely normal pre-anesthesia. Her other differentials were infectious – leptospirosis, cholangiohepatitis – neoplasia, or toxin ingestion. Further workup was declined and the dog was discharged on August 23, 2021.

14. The dog was presented to Dr. Rittenberg on several occasions for recheck. The dog was doing well and was stable.

15. Dr. Rittenberg commented that due to Respondent performing blood work prior to the dental and used safe, appropriate doses of medications, she suspected that the cause was either an idiosyncratic reaction to midazolam or potentially the dog had an underlying primary liver disease that made it more difficult for the dog to process medications. She advised Complainant that there were no abnormalities noted on the blood work prior to the dental procedure, therefore there was no way to have predicted the outcome.

COMMITTEE DISCUSSION:

The Committee discussed that the days that Respondent was in direct care of the dog they did not have any concerns and did not find violation. However, the Committee did have concerns regarding the care that was provided to the dog by Respondent's associates, Dr. Munhall and Dr. Duthie.

Respondent is the responsible veterinarian for the premises.

The Committee had concerns with Banfield's medical record keeping; the inconsistencies and inaccuracies with documentation, for example the dog had a dental on August 14th, however the medical record notes on August 17th that tartar was found – three days after the dental. Additionally, the Committee commented that Banfield schedules many vaccination and dental cleaning appointments but do not have time slots for sick patients. The Committee stated this is a systemic issue and a repeated problem with the Banfield organization.

COMMITTEE'S PROPOSED CONCLUSIONS of LAW:

The Committee concluded that no violations of the Veterinary Practice Act occurred.

COMMITTEE'S RECOMMENDED DISPOSITION:

Motion: It was moved and seconded the Board:

Dismiss this issue with no violation.

Vote: The motion was approved with a vote of 5 to 0.

2nd Motion: It was moved and seconded the Board:

Open an investigation with respect to the care and treatment of the dog by Respondent's associates as well as the Banfield organization with respect to their repeated inaccurate and inconsistent medical record keeping and hospital practices.

Vote: The motion was approved with a vote of 5 to 0.

The information contained in this report was obtained from the case file, which includes the complaint, the respondent's response, any consulting veterinarian or witness input, and any other sources used to gather information for the investigation.

TR

Tracy A. Riendeau, CVT
Investigative Division